

Decline/Waive Coverage Form



To be completed ONLY if declining coverage with Balance for self or eligible dependent

Group Name	Group Number
Name of Declining Employee:	

Complete this form if you are declining coverage for yourself or for your dependents (including your spouse) under this plan because you have health coverage, you may in the future be able to enroll yourself or your dependents in the plan. Your request for enrollment must be submitted to Balance within 60 days after your other coverage involuntarily ends.

In addition, if you are not enrolled under your employer's group health plan and you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. Your request for enrollment must be submitted to Balance within 60 days after the event.

Dependent Name(s)	Dependent Relationship
1.	
2.	
3.	
4.	
5.	

Reason for Declining Coverage	
Please check the reason for declining:	
<input type="checkbox"/> Covered by another employer's health plan through my spouse/DP. Carrier Name & ID Number: _____	
<input type="checkbox"/> Covered by Medicare and/or Medi-Cal	
<input type="checkbox"/> Other: _____	
Signature of Employee Declining Coverage Date	Signature of Employer Date

Employers must retain a copy of any signed decline of coverage form for their records.